

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/21/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152018		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 07/20/2011	
NAME OF PROVIDER OR SUPPLIER KINDRED HOSPITAL NORTHERN INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 215 W 4TH ST STE 200 MISHAWAKA, IN46544			
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S0000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 002605</p> <p>Survey Date: July 18-20, 2011</p> <p>Surveyors:</p> <p>ReBecca Lair, LCSW Medical Surveyor</p> <p>Albert Daeger Medical Surveyor</p> <p>Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>QA: cloughlin 08/01/11</p>			S0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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S0318	<p>410 IAC 15-1.4-1(c)(6)(F)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(F) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and hospital policy for all health care workers, including contract and agency personnel, who provide direct patient care. Based on document review and staff interview, the facility failed to ensure CPR competence for 4 of 10 physicians.</p> <p>1.) Hospital policy #MS-012, titled CPR COMPETENCE, indicated the following: "For both patient safety and quality of care, the Hospital needs to assure those patients who have a cardiac arrest have Hospital and Medical Staff members who are CPR competent. ...Cardiac Resuscitation is considered a Standard of Practice for the following Medical Staff: Cardiologists, Internal Medicine, Hospitalist, Pulmonologists, Nephrologist, Surgeons/Cardiovascular/Thoracic Surgeons, House Physicians--Night Coverage."</p> <p>2.) On 7-19-11 at 12:45pm, upon</p>			S0318	<p>KINDRED HOSPITAL NORTHERN INDIANAMishawaka, IndianaHospital License #011-002605-1Facility #002605INDIANA STATE DEPARTMENT OF HEALTHSTATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONAugust 2011 <input type="checkbox"/></p> <p><u>S318: Completion</u> <u>DateCorrection of Deficiency</u> August 1, 2011The Medical Staff CPR Competency Policy was revised; this included an update of Licensed Independent Practitioner (LIP) based on their specialty. The revised policy now states "Cardiac Resuscitation is considered a Standard of Practice for the following Medical Staff:-- Hospitalist (0700 – 1900 attending/admitting physician daily in-house)-- House Physician – Resident – Night Coverage Only (1900 – 0700 daily in-house</p>		10/14/2011

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	<p>document review, and in the presence of Employee A2, it was noted that 4 of 10 physicians were lacking documentation of CPR competency.</p> <p>3.) On 7-19-11 at 3:45pm per interview with Employee A1, it was verified that there was no CPR documentation available for review.</p>				<p>for emergent situations)." <input type="checkbox"/></p> <p>September 7, 2011The CPR Competency Policy will be approved at the Medical Executive/Credentials Committee on September 7, 2011.</p> <p>Attachment 1</p> <p>September 7, 2011The Medical Executive/Credentials Committee will discuss and determine the dates in which Licensed Independent Practitioners, per policy, will be required to have their CPR competency up-to-date. Attachment 2The proposed time frame will be as follows:ReviewAs of August 31, 2011, 100% of night coverage physicians have current ACLS; 7 out of 10 Hospitalists scheduled have current ACLS.ChangesCurrent ACLS September 1, 2011Effective September 1, 2011, per the CPR policy, any Hospitalist or House Physician – Resident-Night Coverage Only requesting initial appointment or reappointment must provide proof of current ACLS certification. Individuals with certification expiring during the processing of the application will be granted conditional privileges with the understanding that certification will be renewed within 1 month after conditional appointment.</p> <p>October 14, 2011The remaining 3 LIPs are scheduled to attend an ACLS review class on October 13.</p>		

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					<input type="checkbox"/> <u>Corrective Action/Monitoring</u> August 1, 2011 The Medical Staff Coordinator has notified all LIPs without a CPR competency to update their compliance. September 1, 2011 Currently, 7 out of 10 Hospitalists have current ACLS competency. September 7, 2011 3 out of 10 Hospitalists will be notified by letter from the Medical Executive/Credentials Committee of the date CPR certification is due and determination of privileges if the physician remains out of compliance. August 1, 2011 and ongoing The Medical Staff Coordinator will review all new applications for Hospitalist and House Physician – Resident-Night Coverage to ensure the physician has ACLS certification. If ACLS is not current, physician will be notified of the certification requirement, and application will be placed on hold until proof of certification has been received by the Medical Staff Office. August 1, 2011 and ongoing The Medical Staff coordinate maintains a list of LIPs current ACLS status and will notify the LIP in writing 60 days prior to expiration. If certification is not maintained by the LIP within 7 days of expiration, it will be referred to the Medical Director for follow-up. <input type="checkbox"/> <u>Responsible Persons</u> <input type="checkbox"/> Jackie Nadolny, Medical Staff Coordinator <input type="checkbox"/> Suzanne Morgan,		

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S0322	<p>410 IAC 15-1.4-1(c)(6)(H)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially.</p> <p>Based on document review, the facility failed to ensure the Burlodge Tray Delivery System Policy was updated to meet the state requirements for hot and cold holding, 410 IAC 7-24-187.</p> <p>Findings included:</p> <p>1. Triumph Our Lady of Peace Hospital Burlodge Tray Delivery System Policy last reviewed January 2011 stated, "Acceptable standards for hot food is 130 degrees Fahrenheit and cold foods will be below 50 degrees F for fruit and deserts and below 41 degrees F for milk/dairy and cold beverages." The policy noted the Registered Dietician is responsible for</p>			S0322	<p>RN, MS, Director Quality ManagementShaya Mokfi, MD, Medical Director and President, Medical Staff</p> <p><input type="checkbox"/></p> <p>KINDRED HOSPITAL NORTHERN INDIANA Mishawaka, Indiana</p> <p>Hospital License #011-002605-1 Facility #002605</p> <p>INDIANA STATE DEPARTMENT OF HEALTH STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION August 2011</p> <p>S322 <u>Correction of Deficiency</u> Burlodge Tray Delivery System (BTDS) Policy and Procedure was updated/ revised to include (see Attachment 3): Ø Test tray temperature of hot food be maintained at 135 degrees F or above, or cold food be maintained at</p>		09/06/2011

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	<p>doing periodic test trays and to log it on the Temperature and Scoring Guide. The Temperature and Scoring Guide requires hot food to be served above 120 degrees F to be acceptable and cold food to be served less than 55 degrees F to be acceptable standards. The policy and Scoring Guide lacked agreeable acceptable standards.</p> <p>2. Retail Food Establishment Sanitation Requirements 410 IAC 7-24-187, Potentially Hazardous Food; Hot and Cold Holding, states, "Potentially hazardous food shall be maintained as follows: At one hundred thirty-five (135) degrees Fahrenheit or above, and at forty-one (41) degrees Fahrenheit or less."</p>				<p>41 degrees F or below. Ø The contracted service, Saint Joseph Regional Medical Center (SJRCM): a) recording and logging tray line temperature; b) downloading ambient temperatures on a weekly basis; c) tray line temperatures are recorded and logged by the dietician on a weekly basis. Completion date August 13, 2011</p> <p>The BTDS policy and procedure includes that test trays will be performed at Kindred Hospital Northern Indiana by the dietician or designee to ensure that hot food is at 135 degrees F or above and that cold food is at 41 degrees F or below. Hot foods less than 135 degrees will be reheated to 165 degrees and maintained for 15 seconds. Cold foods will be replaced. Completion date August 13, 2011</p> <p>A meeting was held on August 19, 2011 with the Director and Manager of the contracted service and Kindred Hospital Northern Indiana to review the Burlodge Tray Delivery System Policy and Procedure, and discuss any issues related to the food delivery.</p> <p>Meetings will continue as needed to increase communication and initiate problem solving. Completion date August 19, 2011</p>		

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					<p><u>Review</u> During the meeting with the contracted service, the entire process from tray line set-up to delivery to the patient was reviewed. Completed August 18, 2011</p> <p>The Burlodge Tray Delivery System Policy and Procedure was reviewed and updated to include temperature required for hot/cold foods and responsibility of taking recording, and interventions if the temperatures do not meet the standards identified in the policy. Completed August 18, 2011</p> <p><u>Changes</u> Ø Reviewed roles of contracted services for monitoring of temperature. Ø Reviewed role of dietician or designee for monitoring of temperature. Ø Instituted a log for the daily temperature log (Attachment 4) August 18, 2011</p> <p><u>Corrective Action/Monitoring</u> Weekly download logs of the BTDS are to be submitted to the dietician from the contract service weekly (Example 1). August 18, 2011 Ongoing</p> <p>The temperature of hot and cold meals will be taken once a day per meal seven days a week to assure temperatures per the policy and procedure and appropriate action taken.</p>		

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					August 18, 2011 Ongoing The summary of the temperature logs will be reviewed by the dietician weekly. August 18, 2011 Ongoing On a monthly basis the dietician will report to the Chief Clinical Officer the reports with documented action items or follow-up taken. September 1, 2011 The Reports will be submitted quarterly to the Clinical Quality Council. The reports will be a standing agenda item beginning at the next meeting on November 15, 2011. The report will include data from August 1 until October 31, 2011. November 1, 2011 <u>Responsible Person(s)</u> Jane Mason, RN, MS, Chief Clinical Officer Dawna Summers, RhD, Dietician		

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S0330	<p>410 IAC 15-1.4-1(c)(6)(K)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following:</p> <p>(6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(K) Maintaining personnel records for each employee of the hospital which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-ray, as applicable.</p> <p>Based on personnel file review and interview, the facility failed to ensure TB testing/screening was performed according to policy for 14 of 14 staff members (R1- 14).</p> <p>Findings included:</p> <p>1. Review of personnel files on 07/19/11 evidenced the following:</p> <p>A. The last TB testing for staff members R1, R2, R3, R4, R5, R8, R9, R10, R11, R12, and R13 was performed in October of 2009.</p> <p>B. The last TB testing for staff member R6 was performed 01/05/10.</p>			S0330	<p>KINDRED HOSPITAL NORTHERN INDIANA Mishawaka, Indiana Hospital License #011-002605-1 Facility #002605 INDIANA STATE DEPARTMENT OF HEALTH STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION August 2011</p> <p><input type="checkbox"/></p> <p><u>A330: Completion Date</u> <u>Correction of Deficiency</u> <u>Completed July 1, 2011</u> The Tuberculosis Screening of Associates Policy and Procedure was revised and updated to indicate the screening of employees. <u>Completed July 1, 2011</u> The Tuberculosis Screening Questionnaire was updated, and</p>		09/15/2011

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	<p>C. The last TB testing for staff member R7 was performed 03/24/10.</p> <p>D. No TB testing/screening was provided for staff member R14.</p> <p>2. At 12:15 PM on 07/19/11, staff member A1 indicated the facility was informed last fall by the CDC that they were in a low risk county and would no longer have to perform the actual TB testing annually. He/she provided the new policy regarding Tuberculosis screening, dated June 2011, and a revision, dated July 2011. Documentation of board approval of this policy could not be provided. However, this new policy still stated, "...1. A documented TB risk assessment will be reviewed annually as part of the TB Exposure Control plan and TB surveillance will be monitored on an ongoing basis; as a function of the Infection prevention Program."</p> <p>3. The policy in effect last fall, "Tuberculosis Screening of Employees", dated August 2005, stated, "To minimize the transmission of tuberculosis (TB) by employees, volunteers and contract personnel, as an integral part of the [facility name] comprehensive Tuberculosis Control Plan, all employees, volunteers and contract personnel will have an annual screening for TB infection and disease in the month of February."</p>				<p>reviewed to correlate with the Policy and Procedure.</p> <p><input type="checkbox"/></p> <p>Review Completed August 10, 2011 The Policy/Procedure and Screening Assessment were approved by the Infection Prevention/Antibiotic Committee on August 10, 2011 (Attachments 5, 6, 7). Completed August 16, 2011 The Policy/Procedure and Screening Assessment were approved at the Clinical Quality Council on August 16, 2011 (Attachment 8). <input type="checkbox"/> Changes Completed August 17-26, 2011 Employee mandatory staff meetings held August 17-26, 2011 to review the Policy/Procedure and Screening Assessment. September 15, 2011 All employees are required to return their Tuberculosis Screening to their Director by August 31, 2011. <input type="checkbox"/> Corrective Action/Monitoring September 1-15, 2011 ➤ As of 8/31/11, 85% of the employees completed their TB Screening Assessment. ➤ The Chief Clinical Officer is to notify all employees with outstanding assessments that if it is not completed and returned by 9/15/11, they will be suspended from working.</p>		

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S0408	<p>4. At 12:30 PM on 07/19/11, staff members A1 and A8 confirmed that the annual TB screening was missed for the last year and it was not conducted in February of 2011. They confirmed that TB risk assessments had not been completed by the staff.</p> <p>410 IAC 15-1.4-2 (a)(2)(A)(B)(C)(D)</p> <p>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(2) All functions, including but not limited to the following:</p> <p>(A) Discharge planning. (B) Infection control. (C) Medication therapy. (D) Response to emergencies as defined in 410 IAC 15-1.5-5(b)(3)(L)(i).</p> <p>Based on document review and interview, the hospital failed to include dietary services as a part of its comprehensive quality assessment and improvement program (QA&IP).</p>			S0408	<p>Completed August 16, 2011 The Infection Preventionist has responsibility to initiate the TB Screening Assessment annually, beginning October 2012.</p> <p><input type="checkbox"/></p> <p><u>Responsible Person(s)</u></p> <p><input type="checkbox"/></p> <p>Diana Korpai, Infection Preventionist Jane Mason, Chief Clinical Officer Suzanne Morgan, RN, MS, Director, Quality Management</p> <p><input type="checkbox"/></p> <p>KINDRED HOSPITAL NORTHERN INDIANA Mishawaka, Indiana Hospital License #011-002605-1 Facility #002605 INDIANA STATE DEPARTMENT OF HEALTH</p>		08/18/2011

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	1.) Document review failed to show any information as to monitor, standard and reporting information related to dietary services. 2.) Interview with Employee A8 indicated that dietary services are not currently included in quality review.				STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION August 2011 <input type="checkbox"/> <u>S408: Completion Date</u> <u>Correction of Deficiency</u> Completed August 1, 2011 The Dietary Services were not integrated into the Quality Assessment and Improvement Program. The Dietician, Chief Clinical Officer (CCO), and Director of Quality Management have reviewed and implemented criteria for reporting quality assessment monitors from the Dietary Department. <input type="checkbox"/> <u>Review / Changes</u> August 18, 2011 The Contract Service Director, Manager, and Dietician met to review the criteria and patient satisfaction surveys. <input type="checkbox"/> <u>Corrective Action/Monitoring</u> August 18, 2011 Ongoing Criteria was established for monitoring and collection of data as follows: ➤ Daily temperature logs for the Burlodge Trays on a weekly basis, to be submitted from the contract service to dietician (Example 2). ➤ Dietician or designee to monitor test tray daily hot and cold foods (Example 3). ➤ Patient Satisfaction Survey to be reviewed monthly by the dietician and contract services. The survey question on a scale of		

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					1-5, 1 = never, 5 = All the time, "If you received meals during your hospitalization, did you find the food adequate?" September 1, 2011 Ongoing The quality monitoring reports will be submitted monthly by the dietician (beginning monitors August 1), submitted for review with an action plan to the CCO on September 1, 2011. The quality monitoring will be a standing agenda item under clinical services beginning with the next Clinical Quality Council meeting on November 15, 2011 (Example 4). <input type="checkbox"/> Responsible Person(s) <input type="checkbox"/> Jane Mason, Chief Clinical Officer Suzanne Morgan, RN, MS, Director, Quality Management Dawna Summers, RD, Dietician <input type="checkbox"/>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
S0610	410 IAC 15-1.5-2(f)(3)(D)(x) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following: (x) A program of food preparation and storage for all personnel involved in food handling which includes, but is not limited to, the following: (AA) Storage of employee food in patient refrigerators. (BB) Medications in nutrition refrigerators. (CC) Refrigerator and freezer temperature monitoring. Based on observation, document review and interview, the facility failed to ensure the refrigerators for patient food on the 2 nursing units had daily temperature monitoring to ensure food was stored at the required temperatures and failed to ensure safe food handling practices as required by 410 IAC 7-34 Retail Food Establishment Sanitation Requirements as it regards to hot/cold hold of food being served to the patients.			S0610	KINDRED HOSPITAL NORTHERN INDIANA Mishawaka, Indiana Hospital License #011-002605-1 Facility #002605 INDIANA STATE DEPARTMENT OF HEALTH STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION August 2011 A610: Completion Date Correction of Deficiency Completed August 1, 2011 ➤ The two nursing units did not		09/01/2011

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	<p>Findings included:</p> <ol style="list-style-type: none"> During the tour of the Med/Surg unit, beginning at 2:30 PM on 07/19/11 and accompanied by staff members A7 and A8, the logs for the patient food refrigerator were observed lacking some daily temperature documentation. During the tour of the High Observation unit, beginning at 3:15 PM on 07/19/11 and accompanied by staff members A7 and A8, the logs for the patient food refrigerator were observed lacking some daily temperature documentation. At 8:45 AM on 07/20/11, staff member A7 provided the refrigerator temperature monitoring logs for the last 6 months. Review of the logs of the patient food refrigerator on the Med/Surg unit evidenced the following: <ol style="list-style-type: none"> No checks for 16 out of 31 days in January 2011. No checks for 11 out of 28 days in February 2011. No checks for 8 out of 31 days in March 2011. No checks for 6 out of 30 days in April 2011. No checks for 7 out of 31 days in May 2011. No checks for 3 out of 30 days in June 2011. Review of the logs of the patient food refrigerator on the High Observation unit evidenced the following: <ol style="list-style-type: none"> No checks for 7 out of 31 days in January 2011. 				<p>have daily temperature monitoring to ensure patient food was stored at the required temperatures. The temperatures were not recorded.</p> <p>➤ The "Food Safety – Preparation, Handling, and Storage Policy / Procedure" was revised (Attachment 9).</p> <p><input type="checkbox"/></p> <p>Review Completed July 21, 2011 The staff was educated on: a) Maintaining the daily temperature logs for all refrigerators and freezer in the nourishment room. b) Instructions to follow if temperatures were not met. c) The Clerical Coordinators will be responsible for the daily recording in the log and intervention if the temperatures do not meet the standard. d) The dietician will be responsible for daily communication with the Clerical Coordinators to monitor completion of logs and interventions. Completed August 1, 2011 A new digital thermometer was purchased for accurate temperature readings. *See A322 response for additional information <input type="checkbox"/></p> <p>Changes Completed September 1, 2011 The "Refrigerator Temperature Log" was revised (Attachment 9). <input type="checkbox"/></p>		

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	<p>B. No checks for 22 out of 28 days in February 2011.</p> <p>C. No checks for 6 out of 31 days in March 2011.</p> <p>D. No checks for 4 out of 30 days in April 2011.</p> <p>E. No checks for 10 out of 31 days in May 2011.</p> <p>F. No checks for 13 out of 30 days in June 2011.</p> <p>6. At 12:50 PM on 07/20/11, staff member A4 indicated the log sheets stated a daily check was to be done, but there was no policy outlining the procedure or responsible staff member.</p> <p>7. The hot food received on 7/18/2011 included: potatoes at 129 F, grilled chicken breast at 129.5 degrees F, steamed broccoli at 131 degrees F, and carton of milk at 44 F. The temperatures were taken with #D1's dial thermometer. #D1's thermometer was calibrated to 42 degrees F which makes the food actual temperature 10 degrees lower then the actual reading. The food temperatures were taken after the Burlodge hot/cold holding equipment for 10 minutes.</p> <p>8. The Food Temperature and Scoring Guides were reviewed for July, June and May of 2011. On 6/6/11, the chicken breast, red cooked potatoes and steamed broccoli were served to the patients at 126, 128, and 130 degrees Fahrenheit while the 2% milk was served at 50 degrees Fahrenheit. On 6/3/2011, the 2% milk temperatures were 64 degrees Fahrenheit. The temperature logs of the food that was being served to the patients</p>				<p><u>Corrective Action/Monitoring</u> <u>September 1, 2011 Ongoing</u> The quality monitoring reports will be submitted monthly by the dietician (beginning new monitors September 1, 2011). Submitted for review with an action plan to the Chief Clinical Officer on October 1, 2011. The quality monitoring will be a standing agenda item under clinical services beginning with the next Clinical Quality Council meeting on November 15, 2011 (Example 5).</p> <p><input type="checkbox"/></p> <p><u>Responsible Person(s)</u> <input type="checkbox"/> Jane Mason, Chief Clinical Officer Suzanne Morgan, RN, MS, Director, Quality Management Dawna Summers, RD, Dietician 9/7/2011</p>		

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	<p>were not completed on a daily basis.</p> <p>9. At 12:30 PM on 7/18/2011, #D1 indicated the temperature of the food will not be taken until the food has run through a 20 minute cycle in the Burlodge tray system. The equipment will reheat the hot food while the cold food will be cooled. The nurses will not take the temperatures of the food but the food should be at the proper temperatures after removed from the equipment. #D1 indicated the temperature of the food is not taken on every meal but it is done randomly. #D1 requires hot food to be served to patients at 130 degrees Fahrenheit or above and cold food to be served at 50 degrees Fahrenheit or below.</p> <p>10. Retail Food Establishment Sanitation Requirements 410 IAC 7-24-166, Specifications for Receiving Temperatures of Food states, "Refrigerated, potentially hazardous food shall be at a temperature of forty-one (41) degrees Fahrenheit or below when received; Potentially hazardous food that is cooked to a temperature and for a time specified under sections 161 through 163 of this rule and received hot shall be at a temperature of one hundred thirty-five (135) degrees Fahrenheit or above." Section 187 of 410 IAC 7-24 states, "Potentially hazardous</p>						

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S0932	<p>food shall be maintained as follows: At one hundred thirty-five (135) degrees Fahrenheit or above, and at forty-one (41) degrees Fahrenheit or less."</p> <p>410 IAC 15-1.5-6 (b)(4)</p> <p>(b) The nursing service shall have the following:</p> <p>(4) The nursing staff shall develop and utilize an ongoing individualized plan of care based on standards of care for each patient.</p> <p>Based on policy review, medical record review, and interview, the facility failed to ensure the staff followed their policy regarding the initiation of plans of care for 7 of 15 closed medical records reviewed (N3, N4, N6, N10, N12, N13, and N15).</p> <p>Findings included:</p> <p>1. The facility policy titled "Interdisciplinary Team Conference and Plan of Care", last reviewed September 2010, stated, under Policy, "A Plan of Care based on data from assessments is initiated by the Admitting Nurse."</p>			S0932	<p>KINDRED HOSPITAL NORTHERN INDIANAMishawaka, IndianaHospital License #011-002605-1Facility #002605INDIANA STATE DEPARTMENT OF HEALTHSTATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONAugust 2011</p> <p><u>S932: Completion</u> <u>DateCorrection of Deficiency</u> <u>Completed August 15, 2011</u> Nursing Care Plans, the "Interdisciplinary Team Conference and Plan of Care" were reviewed with no changes or updates. <input type="checkbox"/> <u>Review</u> <u>August 11-30,</u></p>		09/15/2011

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	2. The medical record for patient N3 evidenced an admission date of 03/31/11, but no initiation of a nursing plan of care until 04/05/11. 3. The medical record for patient N4 evidenced an admission date of 03/29/11, but no initiation of a nursing plan of care until 03/31/11. 4. The medical record for patient N6 evidenced an admission date of 03/19/11, but no initiation of a nursing plan of care until 03/21/11. 5. The medical record for patient N10 evidenced an admission date of 04/22/11, but no initiation of a nursing plan of care until 04/25/11. 6. The medical record for patient N12 evidenced an admission date of 05/24/11, but no initiation of a nursing plan of care until 05/25/11. 7. The medical record for patient N13 evidenced an admission date of 06/17/11, but no initiation of a nursing plan of care until 06/20/11. 8. The medical record for patient N15 evidenced an admission date of 04/28/11, but no initiation of a nursing plan of care until 04/29/11.				2011 Interdisciplinary Team Conference and Plan of Care Policy and Procedure were reviewed with every admitting nurse. Expectations that the nursing care plan be initiated by the admitting nurse (Attachment 10). September 1-14, 2011 Remainder of admitting nurses to be educated on policy / procedure and expectations. <input type="checkbox"/> Changes August 15 Ongoing The Nursing Supervisor will concurrently review all new admissions for initiation of a Plan of Care by the admitting R.N. The Nursing Supervisor will mentor the admitting nurse immediately if Plan of Care is not initiated. <input type="checkbox"/> Corrective Action/Monitoring August 15, 2011 Ongoing During August 2011, 66% Plans of Care initiated at admission. September 1, 2011 Ongoing Ø Daily admissions will be reviewed concurrently and the initiation of the Plan of Care by the Nursing Supervisor.Ø The Chief Clinical Officer (CCO) will counsel each admitting nurse that did not meet the expectation.Ø The CCO will submit monthly reports to the Director, Quality Management (DQM) of the compliance percentage of "Plan of Care initiated at admission."Ø The percentage of compliance will be a standing agenda item under clinical services beginning with the next Clinical Quality Council		

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S0952	<p>9. At 11:45 AM on 07/20/11, staff members A3 and A4 confirmed the plans of care were not initiated by the admitting nurse in the cited medical records.</p> <p>410 IAC 15-1.5-6(d)</p> <p>(d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). Based on policy review, medical record review, and interview, the facility failed to ensure staff followed their policy for blood administration in 4 of 5 records reviewed of patients who had received blood transfusions (#N1, N3, N4, and N5).</p> <p>Findings included:</p> <p>1. The facility policy, titled "Blood and Blood Product Administration", last reviewed in June 2010, stated on page 2. "... E. Vital signs (TPR & BP) are to be taken and recorded within 60 minutes prior to initiation of each unit of</p>			S0952	<p>meeting on November 15, 2011.</p> <p><input type="checkbox"/> Responsible Person(s)</p> <p><input type="checkbox"/> Jane Mason, Chief Clinical Officer Suzanne Morgan, RN, MS, Director, Quality Management</p> <p><input type="checkbox"/></p> <p>KINDRED HOSPITAL NORTHERN INDIANA Mishawaka, Indiana Hospital License #011-002605-1 Facility #002605 INDIANA STATE DEPARTMENT OF HEALTH STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION August 2011</p> <p>S952: Completion Date Correction of Deficiency Completed August 1, 2011 The "Blood and Blood product Administration Policy and Procedure" stated vital signs (TPR & BP) are to be taken and recorded within 60 minutes of initiation, Fifteen minutes after the start of each unit, and at the</p>		09/28/2011

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	<p>blood/blood product, 15 minutes after start of each unit, and at completion of each unit. F. The transfusionist is to remain with patient for a minimum of 5 minutes (15 preferred) after initiation of transfusion and observe for any signs/symptoms of reaction or patient distress."</p> <p>2. The medical record for patient N1 evidenced a unit of blood started at 1055 on 06/06/11 with the pretransfusion vital signs (VS) documented at 1055 and the 15 minute VS at 1120. (The facility uses military time recording.) A second unit of blood was started at 1430 on 06/06/11 and the pretransfusion VS were documented at 1430 and the 15 minute VS at 1515. The record failed to show documentation of the transfusionist remaining with the patient for the first 5 minutes.</p> <p>3. The medical record for patient N3 evidenced a unit of blood started at 1458 on 04/06/11 with the pretransfusion vital signs (VS) documented at 1444 and the 15 minute VS at 1458, the time of the transfusion start. The record failed to show documentation of the transfusionist remaining with the patient for the first 5 minutes.</p> <p>4. The medical record for patient N4 lacked documentation on the transfusion</p>				<p>completion. The transfusionist was to remain with the patient for at least five minutes after the start of the unit.</p> <p><input type="checkbox"/></p> <p>Review Completed August 1, 2011 Documentation between the electronic medical record and the blood bank records were not consistent: • Vital signs pre-transfusion • Vital signs 15 minutes after start of transfusion • Vital signs post-transfusion (Example 11)</p> <p><input type="checkbox"/></p> <p>Changes Completed August 1, 2011 The Blood and Blood Product Administration Policy and Procedure was reviewed with no changes made. Completed August 15, 2011 The South Bend Medical Foundation Director (Laboratory Contract Services), Chief Clinical Officer and Director Quality Management met to review blood administration process. The process was determined to meet the standards outlined in the policy and procedure. Completed August 16, 2011 The Blood and Blood Product Administration Policy and Procedure was reviewed and approved by the Clinical Quality Council on August 16, 2011 (annual review) (Attachment 11).</p> <p><input type="checkbox"/></p> <p>Corrective Action/Monitoring</p>		

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	<p>record of a start time for a unit of blood on 04/19/11. The electronic medical record indicated documentation of pretransfusion VS at 1610, a transfusion start time of 1600, and VS on an assessment sheet at 1600 and 1630. A second unit of blood on the same date had documentation of a start time of 1835, pretransfusion VS at 1835, and 15 minute VS at 1900. The record failed to show documentation of the transfusionist remaining with the patient for the first 5 minutes.</p> <p>5. The medical record for patient N5 evidenced a unit of blood started at 2145 on 06/01/11 with the pretransfusion vital signs (VS) documented at 2145 and the 15 minute VS at 2205. The post transfusion BP was partially written over the 15 minute BP, making both BPs illegible. A second unit of blood was started at 0040 on 06/02/11 and the pretransfusion VS were documented at 0040 and the 15 minute VS at 0158. The record failed to show documentation of the transfusionist remaining with the patient for the first 5 minutes.</p> <p>6. At 11:00 AM on 07/20/11, staff members A3 and A4 confirmed the record findings and also indicated there was no way it could be determined if the transfusionist remained with the patient</p>				<p>September 7 - 28, 2011 Education Program for (annual) blood administration to all RNs and LPNs to be reviewed: a) Vital signs pre-during and-post transfusion b) informed consent c) staying with patient at start of transfusion d) documentation on Blood Bank forms and electronic medical record.</p> <p>September 1, 2011 Ongoing Concurrent monitoring of 100% blood transfusions for documentation criteria. The CCO will individually counsel the RNs and LPNs who do not meet the standards.</p> <p>September 1, 2011 Ongoing The quality monitoring reports will be submitted with an action plan by the CCO monthly for the standing agenda item under clinical services beginning with the next Clinical Quality Council meeting on November 15, 2011.</p> <p><input type="checkbox"/></p> <p>Responsible Person(s)</p> <p><input type="checkbox"/> Jane Mason, Chief Clinical Officer Suzanne Morgan, RN, MS, Director, Quality Management</p> <p><input type="checkbox"/></p>		

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S1022	<p>for the first 5 minutes, although it was the accepted standard.</p> <p>410 IAC 15-1.5-7 (d)(2)(B)</p> <p>(d) Written policies and procedures shall be developed and implemented that include the following:</p> <p>(2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following:</p> <p>(B) Appropriate storage conditions. Based on observation, document review, and interview, the facility failed to ensure the medication refrigerators on the 2 nursing units had daily temperature monitoring to ensure the quality and efficacy of the medications were maintained.</p> <p>Findings included:</p> <p>1. During the tour of the Med/Surg unit, beginning at 2:30 PM on 07/19/11 and accompanied by staff members A7 and A8, the logs for the medication refrigerator were observed lacking some daily temperature documentation.</p> <p>2. During the tour of the High</p>			S1022	<p>KINDRED HOSPITAL NORTHERN INDIANA Mishawaka, Indiana Hospital License #011-002605-1 Facility #002605 INDIANA STATE DEPARTMENT OF HEALTH STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION August 2011 <u>S1022: Completion Date</u> <u>Correction of Deficiency</u> July 30, 2011 Daily temperature monitoring was not consistent on a daily basis for the temperature of the medication refrigerators. <input type="checkbox"/> <u>Review</u> Completed July 30, 2011 Refrigerator Temperature Check Sheet and Medication Storage</p>		08/30/2011

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	<p>Observation unit, beginning at 3:15 PM on 07/19/11 and accompanied by staff members A7 and A8, the logs for the medication refrigerator were observed lacking some daily temperature documentation.</p> <p>3. At 8:45 AM on 07/20/11, staff member A7 provided the refrigerator temperature monitoring logs for the last 6 months.</p> <p>4. Review of the logs for the medication refrigerator on the Med/Surg unit evidenced the following:</p> <p>A. No checks for 16 out of 31 days in January 2011.</p> <p>B. No checks for 11 out of 28 days in February 2011.</p> <p>C. No checks for 1 out of 31 days in March 2011.</p> <p>D. No checks for 5 out of 30 days in April 2011.</p> <p>E. No checks for 6 out of 31 days in May 2011.</p> <p>F. No checks for 3 out of 30 days in June 2011.</p> <p>5. Review of the logs for the medication refrigerator on the High Observation unit evidenced the following:</p> <p>A. No checks for 4 out of 31 days in January 2011.</p>				<p>Area Inspection Sheet were revised and initiated by the pharmacy staff. This included action codes for follow-up.</p> <p><input type="checkbox"/></p> <p>Changes</p> <p>Completed July 30, 2011</p> <p>➤ The pharmacy staff was instructed on the logging of daily temperature checks for the medication refrigerators.</p> <p>➤ The pharmacy staff was instructed on the monthly medication storage area inspection.</p> <p><input type="checkbox"/></p> <p>Corrective Action/Monitoring</p> <p>July 21, 2011 Ongoing</p> <p>The Medical Surgical and High Observation Refrigerators were checked daily with 100% compliance for July 21-August 31 (Example 7).</p> <p>August 30, 2011 Ongoing</p> <p>The medication storage area and inspection was completed in (this occurs monthly):</p> <p>a) Medical/Surgical Unit</p> <p>b) High Observation Unit</p> <p>c) Radiology Department</p> <p>d) Dialysis Unit</p> <p>All areas met criteria (Example 8).</p> <p>July 27, 2011 Ongoing</p> <p>The Director of Pharmacy is responsible to assure that the temperature checks occur daily and the medication storage area inspection occurs monthly.</p> <p><input type="checkbox"/></p> <p>Responsible Person(s)</p> <p><input type="checkbox"/></p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152018		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 07/20/2011	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>B. No checks for 8 out of 28 days in February 2011.</p> <p>C. No checks for 10 out of 31 days in March 2011.</p> <p>D. No checks for 6 out of 30 days in April 2011.</p> <p>E. No checks for 12 out of 31 days in May 2011.</p> <p>F. No checks for 12 out of 30 days in June 2011.</p> <p>6. At 12:50 PM on 07/20/11, staff member A8 indicated the log sheets stated a daily check was to be done, but there was no policy outlining the procedure or the responsible staff member.</p> <p>7. At 1:00 PM on 07/20/11, the pharmacist, staff member A5, provided the facility policy titled "Medication Storage" which stated on page 1, "...Drugs requiring special storage conditions for stability (e.g., refrigeration or protection from light) are stored as directed." The policy continued on page 2, "...Medication storage area will be inspected by pharmacy personnel monthly. The inspection log is maintained and kept for record." Staff member A5 also provided the monthly pharmacy inspection logs, including the monthly temperature monitoring.</p>				<p>Kwanta NaThalang, PharmD, Director, Pharmacy Jane Mason, Chief Clinical Officer</p>		

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S1168	<p>410 IAC 150-1.5-8 (d)(3)</p> <p>(d) The equipment requirements are as follows:</p> <p>(3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained.</p> <p>Based on observation, document review, and interview, the facility failed to ensure the defibrillators on the units were maintained according to manufacturer's recommendations.</p> <p>Findings included:</p> <p>1. During the tour of the Med/Surg unit, beginning at 2:30 PM on 07/19/11 and accompanied by staff members A7 and A8, the logs for the Philips HeartStart XL defibrillator on the crash cart evidenced documentation of daily checks of the device.</p> <p>2. During the tour of the High Observation unit, beginning at 3:15 PM on 07/19/11 and accompanied by staff members A7 and A8, the logs for the Philips HeartStart XL defibrillator on the crash cart evidenced documentation of daily checks of the device.</p> <p>3. At 8:40 AM on 07/20/11, staff member</p>			S1168	<p>KINDRED HOSPITAL NORTHERN INDIANA Mishawaka, Indiana Hospital License #011-002605-1 Facility #002605 INDIANA STATE DEPARTMENT OF HEALTH STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION August 2011</p> <p><u>S1168: Completion Date</u> <u>Correction of Deficiency</u> <u>Complete August 15, 2011</u> The defibrillators were not maintained according to the manufacturer's recommendations of Phillips Heart Start once per shift.</p> <p><input type="checkbox"/></p> <p><u>Review and Changes</u> <u>Completed August 15, 2011</u> The Code Blue Policy and Procedure was reviewed and updated to indicate changes of:</p> <p>a) Defibrillator to be checked every shift.</p> <p>b) Staff responsible for checking defibrillator.</p> <p>c) If department closed, defibrillator checks will occur when the department re-opens.</p> <p>The Emergency Equipment</p>		09/01/2011

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	<p>A7 provided the June and July 2011 logs for the facility's three defibrillators. The logs evidenced documentation of daily checks and this was confirmed by staff member A7.</p> <p>4. Review of the facility's policy titled, "Code Blue Resuscitation", dated January 2010, stated on page 2 under Daily Maintenance of Code Carts, "...F. Test defibrillator per manufacturer's guidelines."</p> <p>5. Review of the manufacturer's guidelines for the HeartStart XL defibrillator indicated under "Operational Checks", ... "Perform a Shift/Systems Check every shift to verify that the HeartStart XL is functioning properly and to ensure that necessary supplies and accessories are present and ready for use." The guidelines listed exactly what to do to perform the Shift/Systems Check which included running the strip to verify all of the systems.</p> <p>6. At 9:00 AM on 07/20/11, staff member A7 confirmed the defibrillator checks were not performed every shift as recommended by the manufacturer.</p>				<p>checklist form was updated to be current with the Code Blue Policy / Procedure (Attachment 11). August 15, 2011 Instructed Charge Nurse and ACLS on responsibility, frequency, and documentation of Emergency Equipment Checklist.</p> <p><input type="checkbox"/></p> <p><u>Corrective Action/Monitoring</u> September 1, 2011 Ongoing The revised Emergency Equipment checklist will indicate defibrillator checks and documentation once per shift (once every 12 hour shift). The Chief Clinical Officer (CCO) will monitor compliance concurrently and counsel staff members appropriately.</p> <p><input type="checkbox"/></p> <p><u>Responsible Person(s)</u> <input type="checkbox"/> Jane Mason, Chief Clinical Officer <input type="checkbox"/></p>		